

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040861

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 379

FILED NOV 12 1963

VS 300
Rev. 4/59

10808

20808

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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Sedalia		c. CITY OR TOWN Sedalia	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bothwell Hospital		d. STREET ADDRESS (If outside, give location) 2506 Wing Avenue	
3. NAME OF DECEASED (Type or print) JOHN WILLIAM DONNELL		4. DATE OF DEATH Month November Day 7 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-7-1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Colonel		10b. KIND OF BUSINESS OR INDUSTRY United States Army	
11a. FATHER'S NAME George W. Donnell		11b. MOTHER'S MAIDEN NAME Augusta Paster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 5-1922 to 9-1954		16. SOCIAL SECURITY NO. 5-1922 to 9-1954	
17. INFORMANT Mrs. Arlyle M. Donnell		18. NAME OF HUSBAND OR WIFE Mrs. Arlyle M. Donnell	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO (b) Acute Pulmonary edema. DUE TO (c) Coronary Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) anterior lateral wall infarction Left ventricular Hypertrophy with Hypertension		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 12:25 A Month, Day, Year 11-11-1963		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Sedalia Missouri	
21. I attended the deceased from August 25, 1958 to November 7, 1963 and last saw him alive on 17 October 1963		22. DATE SIGNED 7 Nov. 63	
22a. SIGNATURE Stanley D. Fisher M.D.		22b. ADDRESS 500 St. 16th Sedalia Missouri	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-11-1963	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Jefferson City, Missouri	
24. FUNERAL DIRECTOR D.W. Heckart		25. DATE RECD. BY LOCAL REG. Nov. 11, 1963	
26. REGISTRAR'S SIGNATURE Francis J. Sweeney per N. Anderson			

(Licensed Embalmer's Statement on Reverse Side)

NOV 14 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 5253

P. O. Address Edwards, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.